The Heritage Foundation State Backgrounder

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A Policy Analysis for Decision Makers

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CALIFORNIA'S SINGLE-PAYER HEALTH CARE INITIATIVE: A COSTLY BAIT AND SWITCH

INTRODUCTION

After Senate Majority Leader George Mitchell in September announced his decision to abandon health care reform legislation for the 103rd Congress, attention shifted immediately to efforts at the state level. Since then, few state reform efforts have received as much attention as the referendum on the November ballot in California. "Proposition 186, the California Health Security Act" would expand insurance coverage to California residents by creating a single-payer system much like the one currently in place in Canada. A state-run health care system, with an elected Health Commissioner exercising oversight and control over virtually the entire system, would be financed by new payroll taxes on California employers and workers and a new surtax on tobacco products.

If passed, Proposition 186 would become the law. It would lead to full state government regulation and control of health care delivery to all California residents. It would create additional state bureaucracies, essentially eliminate the health insurance sector in California, and significantly alter the way in which health care is provided to Californians. Much like the Canadian system of federal oversight and control of how health care services are provided, Proposition 186 would lead to rationing, a black market for health services, and higher labor costs that would encourage businesses to move to more "business friendly" nearby states such as Arizona, Colorado, and Oregon.

Many working lower- and middle-income families will experience significant tax increases under Proposition 186. While the various versions of the Clinton plan in Congress sought to disguise the taxes businesses would pay, Proposition 186 makes a clear statement: Every Californian and every employer in the state will pay increased taxes. To help contain costs, the bill calls for strict price controls, a prescription drug formulary list which will deny millions of Californians medications available in other states, a

Note: Nothing written here is to be construed as necessarily reflecting the views of The Heritage Foundation or as an attempt to aid or hinder the passage of any bill before Congress.

global budget or ceiling for health expenditures, and—if necessary—even rationing of medical services.

For many Californians the term "single-payer" has a certain appeal, suggesting that the state government will eliminate the need for much paperwork and be able to get the best value per dollar from the health care industry. But this is very simplistic. Californians should remember, for instance, that health care will be run by the same state government charged with administering other much-criticized services, such as education and the welfare system.

The most significant provisions in Proposition 186 would:

- ✔ **Create** a new position of "Health Commissioner," with general oversight of the new state-run and state-administered program.
- ✔ **Establish** a "one-size-fits-all" state-established and state-approved standardized benefits package which would determine the services all Californians receive.
- ✔ **Create** new commissions, sub-agencies, and programs to assist the Health Commissioner.
- ✔ **Impose** new taxes on every resident and business in California.

While proponents of Proposition 186 paint a very simplistic and superficial picture of a single-payer system in which the "government will take care of everything," close scrutiny reveals the complications and problems inherent in such a scheme. Approximately 32 million residents, legal and undocumented, live within California's borders. It has been reported that an estimated 6 million do not have any form of health insurance and are not eligible to receive Medicare or Medicaid benefits.[1] Assuming this figure to be accurate, several questions arise.

Does dealing with the problems of the 6 million Californians currently without coverage really require forcing the other 26 million — who are insured and satisfied with their coverage — into a state-run single-payer system?

Does every Californian want or need the prescribed government-approved standard benefits package? A single-payer system means choice of benefits is sharply reduced.

How much will California businesses have to pay in additional taxes? Private businesses in California will be forced to pay an additional $28.8 billion in new payroll taxes in 1998. Since most payroll taxes "paid for" by employees show up on paychecks as reduced cash earnings, a portion should be added to the extra income taxes paid directly by workers. Heritage Foundation Senior Fellow David Winston calculates this "pass through" means private sector workers will lose $25.4 billion in reduced earnings in 1998 on top of the $9.7 billion collected in direct personal taxes. And that assumes the new taxes are sufficient to pay for the new benefits. Analysis by Winston shows that even if there is a shortfall equal to

1 Carol Brydolf, "Proposition 186, Health Services, Taxes," *California Journal*, Vol. 25, No. 9 (September 1994), p. 8.

the lower amount cited in recent estimates ($32.5 billion), Californians could have to pay on average an additional $2,213 in state income taxes on top of the $813 envisioned in Proposition 186. This would triple the state tax rate paid by the average Californian.

Given the current economic status of California, can residents and businesses afford to finance such a system? With escalating payroll costs, many businesses would lay off workers and slow future job growth or leave the state.

What will happen to federal programs such as the Veterans Administration, Indian Health, and Medicaid? Proponents want to use the funds now going to these programs to fund the new system. But it seems most unlikely that Congress will approve all the sweeping changes even though, without this money, the system would be severely underfunded.

Before Californians vote on Proposition 186, they must know the answers to these questions. Millions of Californians are frustrated with the current health insurance system, but they need to consider very carefully the full implications of moving to a government-run system.

The Uniform State Standard Benefits Package

Much like the ill-fated Clinton plan, Proposition 186 includes a major provision dictating the type of benefits all Californians will have unless they are prepared to pay for additional or different services out of their own pockets. Chapter 4 of Proposition 186 details not only the benefits Californians would be eligible to receive, but the scope of coverage as well.[2]

Proposition 186 empowers the California State Health Commissioner to "Adopt annually a benefits package for consumers which meets or exceeds the minimums required by law."[3] The benefits every Californian must have are as follows:

- ✔ **Inpatient and outpatient health facility or clinic services other than long-term care services as defined in Section 25025(a);**
- ✔ **Inpatient and outpatient professional provider services, including eye care and home health care;**
- ✔ **Diagnostic imaging, laboratory services, and other diagnostic and evaluative services;**
- ✔ **Prenatal, perinatal, and maternity care;**
- ✔ **Durable medical equipment and appliances, including prosthetics, eyeglasses, and hearing aids, as determined by the Commissioner;**
- ✔ **Podiatry services;**

2 "California Health Security Act, Proposition 186," Chapter 4, Benefits, pp. 10-17.
3 "California Health Security Act, Proposition 186," Chapter 5, Governance and Administration, p. 18.

- ✔ **Chiropractic services;**
- ✔ **Kidney dialysis;**
- ✔ **Emergency transportation and necessary transportation for health care services for the disabled, as determined by the Commissioner;**
- ✔ **Rehabilitative care;**
- ✔ **Language interpretation for health care services, including sign language, for those unable to speak, hear, or understand English and for the hearing impaired;**
- ✔ **Blood;**
- ✔ **Outreach, education, and screening services, including but not limited to:**
  - (a) Children's preventive care, well-child care, immunizations, screening, outreach, and education;
  - (b) Adult preventive care, including mammograms, Pap smears and other screening, outreach, and educational services.
- ✔ **Prescription drugs subject to approval by the Health Commissioner and placed on the formulary list;**
- ✔ **Long-term care services for the physical health, mental health, social, and personal needs of individuals with limited self-care capabilities, including:**
  - (1) Institutional and residential care, including Alzheimer's Disease units;
  - (2) Home health care;
  - (3) Hospice care;
  - (4) Home and community-based services, including personal assistance and attendant care;
  - (5) Appropriate access to specialty consultation within long-term care settings;
  - (6) Reassessment of an individual's need for long-term services, conducted at appropriate intervals, but not less than once a year.
- ✔ **Mental health care benefits when determined to be medically appropriate by the Health Commissioner:**
  - (1) Crisis intervention, including assessment, diagnosis, brief emergency treatment, and referral;
  - (2) Outpatient services, including but not limited to adult day care, detoxification services, home health care, psycho-social rehabilitation, and professionally sponsored and profession-

ally supervised self-help and peer-support programs approved by the Commissioner;

(3) Intermediate-level care, including but not limited to intensive day and evening programs and institutional and residential services.

(4) Inpatient health facility services as approved by the Commissioner based on the recommendations of the Advisory Board;

(5) Professional provider services at outpatient, intermediate, and inpatient levels of care, including but not limited to individual, family, and group psychotherapy, medical management, psychological testing and mental health case management, and coordination of care;

(6) Diagnostic imaging, laboratory services, and other diagnostic and evaluative services;

(7) Prescription drugs.

✔ **Dental benefits;**

✔ **Emergency benefits.**

Even such a comprehensive package, of course, does not take into account the different needs and desires of individuals and families. Furthermore, all Californians need to understand that if they suffer from a particular ailment that is not covered in the standard benefits package, or for which coverage is available only after joining a waiting list, they will be denied the necessary medical treatment—or denied it until they have waited in line—unless they can come up with the necessary funds to pay for it themselves. To be sure, the proposition provides that "The Commissioner may expand benefits beyond the minimum benefits described in this Chapter when expansion meets the intent of this Division and there are sufficient funds to cover the expansion."[4] But, as will be explained later, there is little likelihood that sufficient funds will be available to cover additional benefits for 32 million people.

As the debate over a standardized plan in Congress made clear, moreover, Californians can expect special-interest health care provider lobbying of the Health Commissioner and the advisory boards and councils. The aim will be to include particular benefits or services in the fine print of the standard benefits package. If the lobby is influential enough, the benefit will be added by the Commissioner. However, the more benefits that are added to the original package, the higher the price tag. This means higher taxes on Californians and businesses—or cutbacks to reduce the costs of other services.

4 "California Health Security Act, Proposition 186," Chapter 4, Benefits, p. 16.

NEW BUREAUCRATS AND BUREAUCRACIES

Under Proposition 186, the Office of the California State Health Commissioner is to be created as an agency of the State of California. The first Health Commissioner is to be appointed by the Governor and confirmed by the California legislature. Thereafter, the Commissioner will stand for election at the same time and in the same manner as the Governor. Also created within the Office of the State Health Commissioner is a Deputy Health Commissioner, appointed by the State Health Commissioner, whose duties include assuming the responsibilities of the State Health Commissioner should he or she become unable to perform the duties of office.

The powers and responsibilities of the State Health Commissioner are very broad: "The Commissioner's powers include any and all powers necessary and proper to implement this Act, and to promote its underlying aims and purposes. These broad powers include, but are not limited to, the power to set rates and promulgate generally binding regulations on any and all matters relating to the implementation of this Act and its purposes."[5]

In other words, one individual will run and administer a new health care system for 32 million Californians. The Commissioner will adopt a standardized benefits package for the entire state population each year, ensure that all health care providers are paid in a timely fashion, take bids for prescription drug contracts under a state-run drug formulary, and negotiate or set rates, fees, and prices involving any aspect of the Health Security System.

These responsibilities are unprecedented in scope. To assist in implementing them, the Commissioner is given power to establish, appoint, and fund:

1. **A Health Policy Advisory Board;**
2. **A Regional Administrator with appropriate staff for each System Region;**
3. **A Regional Consumer Advocate with appropriate staff for each System Region.**

The Health Policy Advisory Board

The Health Policy Advisory Board is to consist of health care and public health professionals who are salaried and compensated in other manners as determined by the Commissioner. Proposition 186 does not specify the number of members who will serve on this newly created board. While this issue may seem trivial now, such an advisory board could expand to accommodate many of the special-interest groups which can be expected to lobby the Commissioner for representation on the board. Depending on who is appointed, there could be serious doubts about the objectivity of board recommendations.

5 "California Health Security Act, Proposition 186," Chapter 6, Governance and Administration, Article 2, Sec. 25063, p. 18.

According to section 25070, the Advisory Board shall:

- ✔ **Make** policy recommendations on medical issues, population-based public health issues, research priorities, scope of services, and expanding access to care and Health Security System evaluation;

- ✔ **Recommend** expert task forces, including an expert formulary (drug) committee, to be appointed by the Commissioner to study and make recommendations on specialized areas of medical policy and effectiveness.

Californians have great reason to be cautious of this seemingly innocent provision. The "expert formulary committee" in particular will have an impact on every resident, especially the poor. A "drug formulary" is a restricted list of approved prescription drugs that a program will cover. In the context of Proposition 186, a formulary committee most likely would monitor the prices of prescription drugs and determine whether they are "reasonable." It would then make a list of recommendations to the Health Commissioner stating which prescription drugs met certain criteria and should be placed on the formulary list. While the bill does not detail or mention the criteria, current state policy includes factors such as economies of scale and presumed therapeutic benefit. If the formulary committee thinks a price for a drug is "unreasonable," the Commissioner likely would exclude that particular medication from the formulary list. Thus, Californians could face a situation in which the drug recommended by their physician is not available under the system.

While a formulary list will affect every Californian's ability to gain access to the latest drug breakthroughs and medicines, it will have an especially adverse effect on elderly, poor, and minority patients. Middle-income and wealthy patients will still be able to purchase medically necessary drugs out of their own pocket, even if these drugs have not been approved by the Health Commissioner. However, current Medicaid recipients and the working poor not eligible for Medicaid effectively will be denied access to these treatments. Testifying before Congress against formularies, Hispanic leader Suleika Cabrera-Drinane pointed out the implications of this for minorities: "If this plan becomes law, Latinos would once again be relegated to the status of second class citizens. We would again be denied equality of treatment under the law. Formularies mean that people will get sick and die because they couldn't get the medicines their doctors said they needed."[6] The Hispanic-American community makes up approximately 26 percent of the state's population. It is very likely that this particular minority will bear a disproportionate share of the adverse consequences of drug formularies.

Given the troublesome history of Medicaid formularies throughout the states, it is ironic that the largest state in the union might adopt such a problematic scheme for its entire population.

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6 Suleika Cabrera-Drinane, Founding Executive Director of the Institute for Puerto Rican/Hispanic Elderly, testimony before Congress, cited by Pharmaceutical Manufacturers Association, *The Case for the Pharmaceutical Industry, 1993-1994*, p. 10.2.

Regional Administrators

Proposition 186 creates what appears to be a mid-level bureaucratic position of "Regional Administrator" to oversee newly designed "System Regions." Each Regional Administrator is charged with such duties as the following:

- ✔ **Negotiating** service contracts;
- ✔ **Preparing** budgets;
- ✔ **Approving and funding** of capital expense projects of health facilities and clinics in the region;
- ✔ **Following** guidelines and formulas determined by the Commissioner.

Essentially, each Regional Administrator will have the power to negotiate prices for physician, hospital, medical equipment, and prescription drug reimbursement. He or she will then forward these prices and further recommendations to the State Health Commissioner, who must coordinate these figures with the projected expenditures from other Regional Administrators.

In addition to a Regional Administrator, each System Region is staffed by a Consumer Advocate appointed by the State Health Commissioner. The Consumer Advocates are charged with, but not limited to, examining the following:

- ✦ **Complaints and suggestions from the public;**
- ✦ **Proposals to be considered by the Commissioner in the future;**
- ✦ **The Commissioner's plans for changes in resource allocation;**
- ✦ **The extent to which individual health facilities and clinics in a System Region meet the needs of the community in which they are located;**
- ✦ **Any other factor bearing on the effectiveness of the Health Security System.**

Proposition 186 is not explicit as to how or by whom the System Regions are to be designed. It is reasonable to assume the state legislature will have a role in this process. Should that be the case, it will be a political nightmare. The reason: each state legislator will want to craft the System Regions so that each is in a strong economic position to shoulder the new taxes and administrative burdens. But more affluent regions will want to avoid inclusion in regions that are disproportionately poor. Gerrymandering disputes could tie up the state court system for years.

The Cost to Californians and Employers, and its Effect on Employment

Proponents of Proposition 186 constantly tout the "savings" they will achieve by eliminating "excessive administrative costs" in the private insurance market. Not only is it highly questionable whether government control would bring sharp improvements in efficiency, but seemingly overlooked is the indirect regulatory cost of the new bureaucracies, commissions, and agencies that would be created. Even without these indirect

costs, however, the system would be extremely expensive—and there is good reason to assume that the sponsors' optimistic budget forecasts mask a huge problem of under-funding.

Proposition 186 relies mainly upon three new taxes to help finance the new health system: a business payroll tax, a personal income tax surcharge, and an increased cigarette tax.

Payroll Tax. The payroll tax is to be levied upon every employer within the state. Self-employed individuals are exempt from the payroll tax but not from the income tax. Proponents of Proposition 186 claim that every employer will be required to pay the payroll tax. They therefore assume that the current exemption for self-insured employers will no longer apply to the state of California—but according to top congressional staffers, this is not necessarily a valid assumption. The payroll tax is structured as follows:

Employers with fewer than 10 employees	4.4% of payroll
Employers with between 10 and 24 employees	6.0% of payroll
Employers with between 25 and 49 employees	7.0% of payroll
Employers with 50 or more employees	8.9% of payroll

If Proposition 186 were to pass, estimates the Palo Alto, California, econometrics firm of Spectrum Economics, Inc., approximately 300,000 jobs would be lost by 1998.[7] Short-term job loss in the insurance sector alone is estimated to be 40,000. Spectrum also forecasts that the wage tax will be passed on in the form of lower wages in future years. As noted by the Congressional Budget Office, "An often overlooked point is that the employer share of the cost of 'employer provided' health insurance is ultimately passed on to workers in the form of lower wages and reductions in fringe benefits other than health insurance...."[8]

A new payroll tax on employers to help pay for the new health care system will add significantly to the labor costs of firms currently not offering health insurance. For firms currently providing health benefits that are not as expensive as the tax cost of the package mandated in the bill, labor costs also will increase. In addition to wage reductions that will tend to follow as firms struggle to offset these costs, some costs also will be passed on in higher prices for consumers, which in turn leads to fewer purchases of non-medical goods and services, ultimately resulting in lower employment in those industries.[9] Depending on the size and financial condition of the firms, the job loss will be felt either immediately or gradually over several years.

7 Spectrum Economics, "Economic Impacts: 1994 California Health Initiative," June 28, 1994, p. 5.

8 Congressional Budget Office, "The Tax Treatment of Employment Based Health Insurance," March 1994, Introduction.

9 Spectrum Economics, "Economic Impacts: 1994 California Health Initiative," p. 5.

It is estimated by Dwayne Banks of the University of California that the new wage tax would generate $42.1 billion of new revenue in 1998.[10] However, economics and common business practice suggest that this may be difficult to achieve. First, many employers would reduce their tax liability by downsizing their firms or restructure their organizations by shutting down in-house departments and then creating subsidiaries. Second, employers who find it economically feasible to self-insure instead of paying the wage tax will do so, thereby avoiding the new tax entirely. As mentioned earlier, proponents also are banking on Congress to waive the ERISA law as it applies to self-insured employers in California, thereby subjecting these firms to the proposed payroll tax. If they fail to achieve a sweeping waiver, as seems likely, revenues will be reduced.

Income Tax. Proposition 186 places an additional 2.5 percent income tax surcharge on Californians of all income ranges. Residents who earn more than $250,000 per annum are responsible for an additional 2.5 percent surtax on top of the original 2.5 percent increase. The state of California already has one of the highest personal income tax rates in the country.

Spectrum Economics estimates that this new income tax will generate $12.5 billion of new revenue in 1998. However, this new tax structure and benefits system will have certain direct and indirect costs. For one thing, some Californians will decide to relocate in other states to reduce their taxes. For another, the new tax policy and benefit system will attract three population groups to the state who are likely to take advantage of a single-payer system: uninsured people needing high-cost health care, early retirees without health insurance, and those in need of long-term care and nursing homes.[11]

Heritage Foundation Senior Fellow David Winston has conducted an analysis of Proposition 186 to estimate the tax implications for Californians working in the private sector. Using a slightly different methodology from that used by Spectrum, he estimates that the new income tax will raise $9.7 billion in 1998 directly from Californians in higher personal income tax payments. But there are other effects. Businesses will face new payroll taxes amounting to a projected $28.8 billion in 1998. The economic literature indicates that when a payroll tax is imposed on an employer, an average of 88 percent of the cost is "passed through" to employees in the form of lower wages (usually reduced raises). The rest of the payroll tax takes the form of higher prices or reduced profits.[12]

The Heritage study suggests that the combined cost (taxes plus wage effects) to Californians employed in the private sector will be $34.8 billion in 1998, or an average of $2,823 per employee. To be sure, this cost is for certain benefits available under the program, and many businesses will be paying the new payroll tax instead of

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10 Dwayne A. Banks, "The California Single-Payer Initiative: Revenue and Expenditure Projections, 1996-2000," Graduate School of Public Policy, University of California, July 1994, p. 27.

11 Spectrum Economics, "Economic Impacts: 1994 California Health Initiative," p. 7.

12 John C. Liu, "What the CBO Says About the Tax Treatment of Employment-Based Health Insurance," Heritage Foundation *F.Y.I.*, No. 16, May 25, 1994, p. 4.

providing benefits. Thus, the net impact on each employee will depend on the current cost (and its wage effect) of the worker's employer-provided benefits—if any.

Two important caveats apply to this comparison, however. The first is that the Heritage calculation takes at face value the claim of proponents that the new taxes in Proposition 186 are sufficient to cover the promised benefits. This is very doubtful, for reasons explained elsewhere. If there were a shortfall, and yet benefit levels were retained, it would be necessary to raise additional revenue, probably through increased tax rates. The possible level of these new revenues is cited later in this analysis, based on the anticipated shortfall.

The second, related to this, is that it is difficult to predict how people, including residents of other states, will react to passage of the California proposition. One reaction may be the movement of some taxpayers and businesses out of the state. Another unanticipated effect could be the movement of other people into the state to take advantage of the new program, pushing up costs without producing much new revenue. Consider, for instance, the proposed long-term care benefits. Since the legislative language only requires individuals to reside in California and pay income taxes for a minimum of two years in order to be eligible for long-term care benefits, younger and healthier long-term residents will end up subsidizing the costs of early retirees moving to California. Despite the requirement to pay income taxes in order to be eligible for long-term care and nursing home services, the revenue collected by the state is not likely to cover the prohibitively expensive costs associated with providing such care. According to the latest U.S. Census data, California already has 3.1 million residents over the age of 65, or approximately 11 percent of the state's population.[13] With such low eligibility requirements for long-term care and nursing home services, it will be very attractive for early retirees not now receiving such generous health benefits to migrate to California.

The Numbers in Proposition 186 Don't Add Up

Even under the most optimistic scenario, in which all new taxes and savings yield the amounts assumed under Proposition 186, expenditures are likely to exceed revenue by a significant margin. A study performed by Dwayne A. Banks of the Berkeley Institute for Research on Policy Solutions (BIRPS) concludes that Proposition 186 would run deficits at least between 1996 and 2000.[14] The assumptions in this study are based upon those used by the Congressional Budget Office, the same agency which forecasts the costs of federal programs as envisioned by the U.S. Congress. CBO assumptions regarding likely consumer and provider reaction to a new single-payer-type system were reflected in the BIRPS study.[15]

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13 Congressional Quarterly's *Politics in America, 1994, 103rd Congress*, (Washington, D.C., Congressional Quarterly, 1993), p. 97.

14 Banks, "The California Single-Payer Initiative: Revenue and Expenditure Projections," p. 27.

15 Congressional Budget Office, "Behavioral Assumptions for Estimating the Effects of Health Care Proposals," November 1993, Appendix F.

According to the BIRPS study, the demand for existing health care services will increase for two reasons. First, out-of-pocket expenditures are virtually zero under the single-payer system, which means that consumers who are currently insured will increase their demand for certain services (such as chiropractic, substance abuse, and dental services) for which they generally now must pay themselves. Second, those who are currently uninsured will have access to services to which they traditionally have not had access, and this will lead to an even greater increase in the overall demand for services.[16]

Even under optimistic assumptions, the BIRPS study estimates that Proposition 186 will cost $135.1 billion in 1998. This is the projected cost of providing the guaranteed benefits to every eligible California resident, legal and illegal. Revenue estimates which include the three major taxes (personal, payroll, cigarette), the federal money gained by the state from taking over Medicare, Medicaid, Worker's Compensation, alcohol and drug abuse services, mental health services, public health services, and indigent care services, together with the projected administrative savings, equals $101.1 billion in 1998. With respect to the ERISA exemption issue, Spectrum estimates that the cost of care for ERISA-exempt workers would roughly equal the payroll tax, thus having little effect on Proposition 186's expected deficit.[17] This presents the California State Health Commissioner with a $34 billion deficit in 1998,[18] leaving the Commissioner with one, or a combination, of the following possibilities to address the deficit: implement stricter cost control mechanisms, request additional funds from the state legislature (that is, higher taxes), or establish co-payments or exclusions on certain services that had been fully covered.

Proposition 186 Relies Too Heavily on Assumptions Based on Fantasy

Proponents of Proposition 186 apparently overestimate the influence of California's congressional delegation in the House and Senate. While California is fortunate to have two House Members as chairmen of powerful committees,[19] their positions on certain health programs are not always supported by a majority of their colleagues. The reason is very simple: Certain changes in the Medicaid and Medicare program which will benefit health care providers and their constituents in Beverly Hills and the San Francisco Bay Area may not be as attractive to a Member of Congress who represents a poor inner-city neighborhood or a rural area.

Furthermore, California's congressional delegation is not known for its ability to cross political party lines and work together on projects portrayed as beneficial to the state. It is surprising that proponents place complete faith and confidence in their Repre-

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16 Banks, "The California Single-Payer Initiative," p. 38; citing CBO, "Behavioral Assumptions for Estimating the Effects of Health Care Proposals."

17 Spectrum Economics, "Proposition 186: Alternative Estimates of Cost and Revenues," August 15, 1994, p. 2.

18 *Ibid.*; Banks, "The California Single-Payer Initiative," Table 1a, p. 27.

19 Henry Waxman is a 10-term Representative from Los Angeles who chairs the powerful House Energy and Commerce Subcommittee on Health and Environment, which has extensive jurisdiction over public health programs, Medicaid, and prescription drug pricing formulas. Fortney (Pete) Stark is an 11-term Representative from Hayward who chairs the influential House Ways and Means Subcommittee on Health, which has jurisdiction over Medicare and Social Security programs.

sentatives' ability to obtain the federal waivers that are needed for Proposition 186 to function effectively.

Paying for the Revenue Shortfall: 1998

	Rate	Costs as Mandated by Proposition 186	Employers Pay for All Shortfall		Individuals Pay for All Shortfall	
			Banks	Spectrum	Banks	Spectrum
Shortfall			$32,500,000,000	$50,700,000,000	$32,500,000,000	$50,700,000,000
Increase to Proposition 186 Payroll Tax			7.1%	11.0%	0.0%	0.0%
New Business Wage Taxes	**Rate**					
Under 10 Employees	4.4%	$2,415,577,808	$6,301,134,198	$8,477,045,777	$2,415,577,808	$2,415,577,808
10-20 Employees	6.0%	$2,173,481,919	$4,737,314,386	$6,173,060,567	$2,173,481,919	$2,173,481,919
20-49 Employees	7.0%	$4,046,144,403	$8,137,132,348	$10,428,085,597	$4,046,144,403	$4,046,144,403
50+ Employees	8.9%	$20,212,613,959	$36,286,368,663	$45,287,671,298	$20,212,613,959	$20,212,613,959
Total*		**$28,847,818,089**	**$55,461,949,595**	**$70,365,863,239**	**$28,847,818,089**	**$28,847,818,089**
Direct Tax to Individuals						
Increase to Personal Income Tax Rate		2.5%	2.5%	2.5%	9.3%	13.2%
Average Tax Increase (Both Private and Public Sector Workers)		**$813**	**$813**	**$813**	**$3,026**	**$4,295**

Note: * Only the private sector share of the increases is reflected. State and local public sector entities would also pay the new payroll tax.

One mistake is to assume that Congress will continue to make federal payments currently going towards the Medicare and Medicaid programs in California with minimal oversight. The two primary committees with jurisdiction over these programs are Ways and Means and Energy and Commerce. These two committees have 82 members, of which California provides only 8. A majority of members on each committee already have stated publicly their opposition to a single-payer system as envisioned in Proposition 186. Thus, it seems unlikely that these committees will act to grant California the right to use federal Medicare and Medicaid payments to help finance the new state system.

Proponents also assume that the federal government will continue its payments to Sacramento toward all programs such as the Veterans Administration, Indian Health Services, and armed forces while current beneficiaries of these programs will be folded into the new state program. Proposition 186 assumes that California will continue to administer current medical and public health programs run by the state. Proponents of Proposition 186 thus assume that California will be allowed to combine projected expen-

Assumptions of Heritage Analysis

1) 1991 *County Business Patterns* was the source for employment, wages, and firm size.
2) Bureau of Labor Statistics was source for information on wage growth.
3) Census Bureau population growth projections were used to estimate change in size of employement for 1998.
4) The cutoff for size of firm was 20 instead of 25 because of limitation of *County Business Patterns* data.
5) California wage projections were applied to 1991 data to estimate 1998 data.
6) California successful in getting ERISA waiver.
7) Business would eventually pass through 88% of health care costs to employees.
8) Shortfalls are based on estimates made by Professor Dwyane Banks of the University of California - Berkley and Dr. Richard Carlson of Spectrum Economics.

ditures for these programs with anticipated federal revenues and that this will be the "new revenue" sufficient for running a new health care system.

The problem is that these projected new revenues—even if they do all materialize—appear to be well short of the amount needed to finance the promised benefits. The BIRPS study, by Dwayne Banks, estimates that the state of California could expect to receive $38.1 billion in combined revenue from existing state and federal programs, leaving a shortfall in 1998 of $32.5 billion for covering workers in the private sector.[20]

Heritage Foundation Senior Fellow David Winston has estimated the possible tax impact of a shortfall of $32.5 billion in 1998, as well as the $50.7 billion shortfall envisioned by Spectrum. Assuming no benefits are cut from the program because of any shortfall, and assuming California is successful in gaining the waivers it needs to generate certain revenues from business (which is far from likely), Winston calculated the new taxes necessary to cover a 1998 shortfall. He calculated the impact under two specific scenarios:

SCENARIO 1: The entire shortfall is recouped through higher payroll taxes on employers. According to the Heritage analysis, and assuming a shortfall of $32.5 billion, California businesses would be hit with a payroll tax of about double the rate envisioned in Proposition 186, if the program is to be fully funded.

SCENARIO 2: The entire shortfall is recouped through higher individual income taxes. The Heritage analysis indicates that if Californians have to shoulder a $32.5 billion shortfall by an increase in their state tax rates, the average Californian would not have to pay the $813 envisioned by Proposition 186 (a 2.5 percent additional tax rate), but $3,026 (or a 9.3 percent additional tax rate). Thus average Californians would see their state individual tax rates triple. And this does not even include the "pass through" wage effect discussed earlier.

GLOBAL BUDGETS, PRICE CONTROLS, AND RATIONING

Chapter 7 of Proposition 186 is entitled "Appropriations, Budgeting, and Expenditures." A more accurate title would be "Global Budgets, Price Controls, and Rationing." Proposition 186 calls for "Expenditure Limits" complemented by a "Global Budget."[21] According to section 25150, "It is the intent of the people that expenditures under this Act not exceed in any year expenditures for the prior year adjusted for changes in the state's gross domestic product and population." Hence, the central cost containment mechanism is not competition and consumer preference, but a fixed system of caps on health care spending.

Proponents of Proposition 186 envision a system in which most health spending in the state of California would be fixed by a government "global budget" and budgets enforced with spending caps. Californians who wanted to purchase insurance for a medical

20 Banks, "The California Single-Payer Initiative," p. 15. The $32.5 billion shortfall is a (reduced) estimate calculated by Banks in October.

21 "California Health Security Act, Proposition 186," Chapter 7, Article 1, sec. 25150, and Article 2, sec. 25158.

service not covered in the state-approved standardized benefit package, or of a better quality, could do so with their own resources. Proposition 186 thus would change dramatically the way in which Californians receive medical care. Since spending on health care at the System Regions level will be fixed according to regional targets and allotments based on the state budget, patients and physicians will have to compete against each other for a fixed quantity of medical services.

The result would be limits in the availability of services for Californians now used to obtaining the services their physicians recommend.[22] In an effort to stay within the expenditure limits imposed by the bill while trying to maintain the level of services demanded, price controls would have to be applied throughout the health care system. These controls would have to be severe, since the growth of health care spending in California would have to be reduced more rapidly than has been possible so far in most industrialized nations—including those with government controls on health care spending (see Table 1). To place such a tight limitation on expenditures would dramatically alter the quality and availability of health care to which Californians have become accustomed.

Table 1

AVERAGE ANNUAL GROWTH IN PER CAPITA HEALTH EXPENDITURES, 1985-1991

(Adjusted for Inflation)

Country	Growth
Turkey	9.61%
California **(projected annual increase for 1995)**	**8.50%**
Spain	6.69%
Italy	5.55%
Finland	4.97%
Iceland	4.48%
Norway	4.30%
Japan	4.24%
Belgium	3.95%
United Kingdom	3.84%
Canada	3.58%
France	3.26%
Austria	3.05%
Germany	2.05%
Switzerland	1.82%
Sweden	0.48%

Numbers represent the percentage by which the increase exceeds the rate of inflation, as measured by the GDP inflator.
Sources: Organization for Economic Cooperation and Development, 1985-1991 comparison; Proposition 186 as drafted in legislative language.

22 John C. Liu, "Clinton Heavy: The Kennedy Bill," Heritage Foundation *Issue Bulletin* No. 197, July 21, 1994, p. 15.

To keep within the expenditure limits, the State Health Commissioner would have an incentive to reduce reimbursements to physicians, hospitals, pharmaceutical companies, and medical equipment manufacturers. If this fails, the Commissioner or the state legislature would be forced to intervene and implement stricter price controls. But price controls always result in unintended consequences. They lead to such things as shortages in the latest medical technology (medical equipment, pharmaceutical drugs, and biotechnology breakthroughs) and a black market which benefits well-connected and wealthy consumers at the expense of others.[23] Californians should consider the average waits Canadians have had to endure under a single-payer system controlled by their government.[24]

Table 2

AVERAGE 1993 PATIENT WAIT TO SEE A SPECIALIST IN CANADA
(After Referral from a General Practitioner)

PROCEDURE	AVERAGE WAIT	LONGEST WAIT
Gynecology	4.87 weeks	7.0 weeks
Ophthalmology	8.65 weeks	8.65 weeks
Otolaryngology	3.53 weeks	3.53 weeks
General Surgery	2.71 weeks	4.30 weeks
Neurosurgery	7.13 weeks	20.0 weeks
Cardiology	3.36 weeks	7.5 weeks
Urology	5.89 weeks	8.0 weeks

The alternative to price controls in Proposition 186 doubtless would be equally offensive to Californians: stripping benefits and services from the package. Article 8, section 25226 allows the State Health Commissioner to "Identify and eliminate wasteful and unnecessary care that is of no benefit to patients receiving that care." A more realistic interpretation perhaps should read: "If the State Health Commissioner realizes that the package is too expensive and that the price controls embodied in the new system won't hold down costs as envisioned, benefits will be struck publicly from the state benefits package."

CONCLUSION

In light of the 103rd Congress's inability to pass a health care reform proposal, it is understandable that Californians are frustrated and feel the need to take the initiative on their own. However, reform at the state level needs to be considered carefully.

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23 Edmund F. Haislmaier, "Why Global Budgets and Price Controls Will Not Curb Health Costs," Heritage Foundation *Backgrounder* No. 929, March 8, 1993, p. 3.

24 Cynthia Ramsay and Michael Walker, "Waiting Your Turn: Hospital Waiting Lists in Canada," Fraser Institute *Critical Issues Bulletin*, Fourth Edition, 1994, p. 23.

Proposition 186 places heavy new payroll taxes on every employer in the state, which in turn would inevitably mean lower wages and job losses in many industries. Like the Clinton plan, which was rejected overwhelmingly by the American public, Proposition 186 would force 32 million Californians into a state government-designed standardized benefits package. Global budgets and price controls inevitably would reduce the quality and quantity of health care for millions of Californians. And like that of the rejected Clinton plan, the financing scheme in Proposition 186 appears to be completely inadequate to fund its promised benefits.

Proponents of Proposition 186 envision a sharply reduced pattern in the growth of future health expenditures, combined with a dramatic improvement in efficiency, if complete control of California's health care system is handed over to the state government. Californians should consider carefully the likelihood of this—and the implications if this rosy scenario does not materialize. Are they prepared to accept the waiting periods experienced throughout the provinces in the Canadian system? Are they prepared to accept the wage reductions and job losses that would accompany increased payroll taxes? Are they comfortable with the idea of a powerful state commissioner determining the details of their coverage? It is these fundamental questions that Californians must consider when they cast their ballots on Proposition 186.

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